MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

3315 West Truman Blvd.
P.O. Box 58
Jefferson City, MO 65102-0058

HEALTH CARE PROVIDER'S RESPONSE TO REQUEST FOR AWARD ON UNDISPUTED FACTS IN REGARD TO APPLICATION FOR DIRECT PAYMENT

Pursuant to 8 CSR 50-2.030(2)(I)(b) the health care provider shall file its response to the award on undisputed facts within thirty days.

_____, Health Care Provider,

vs.

_____, Employer,

and

_____, Insurer

Medical Fee Dispute No: ____ - _____

Injury No.: ____ - _____

Employee (Patient): _____

Date of Accident/ Occupational Disease: _____

RESPONSE TO REQUEST FOR AWARD ON UNDISPUTED FACTS

Health Care Provider _____ herein, for its response to the
(name of health care provider)

REQUEST FOR AWARD ON UNDISPUTED FACTS filed by Employer/Insurer states as follows *(attach additional sheets, if necessary)*:

In support of its statements, Health Care Provider attaches the following exhibits *(attach additional sheets, if necessary)*:
Please identify each exhibit by numbers "1," "2," etc. and by general description of the document.

_____ Health Care Provider Signature & Date

_____ Health Care Provider Address & Telephone No.

_____ Health Care Provider's Attorney Signature & Date *(if applicable)*

_____ Attorney's Address & Telephone No.

CERTIFICATE OF SERVICE

I, the undersigned, certify that, a copy of this Response to Request for Award on Undisputed Facts is true and accurate, and I further certify that a copy of this Response to Request for Award on Undisputed Facts has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP